

**CORPORATE GUARDIANSHIP ANNUAL REPORT**

Completion of this form is required by s. HFS 85.03(10). Failure to complete and submit this form may result in the withdrawal of the Department of Health and Family Services finding of suitability for your corporation per s. HFS 85.04. Direct questions about completion of this form to 608-264-9888.

Name – Organization

Address

City	State	Zip Code
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Name – Contact Person	Number of Wards Approved to Serve
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Title – Contact Person	Telephone Number	Actual Number of Wards Served This Year
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Identify Disability Groups Served

Identify Geographic Areas Served

**NUMBER AND TYPES OF PERSONS SERVED**

GUARDIANSHIPS		PERSONAL / FINANCIAL DECISION MAKING	
Temporary Guardian		Conservatorships	
Standby Guardian		Spendthrifts	
Guardian of the Person Only		SSA / SSI Representative Payee	
Guardian of the Estate Only		Child Guardian	
Guardian of Both the Person and Estate		Other, specify	

**IDENTIFY ALL STAFF MEMBERS (EMPLOYEES AND VOLUNTEERS)**

For staff members added this year, attach a summary of qualifications and a job description.

Attach additional pages as necessary

Name	Job Title	Date Began	End Date
1.			
2.			
3.			
4.			
5.			
6.			

**IDENTIFY BOARD MEMBERS**  
Attach additional pages if necessary.

Name	Office Title	Date Began	End Date
1.			
2.			
3.			
4.			
5.			
6.			

Are any staff or board members also members of any public human services agency? ☐ Yes ☐ No  
If yes, list the name of staff or board member, the agency affiliation and the county.

Summarize your fee and expenses policy. Describe how these amounts were determined. Identify court approved fees.

Briefly summarize your program activities over the past year.

Name – Person Completing This Form	Title	Date Signed
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Return the completed form to:  
  
Bureau of Quality Assurance  
Assisted Living Section  
Corporate Guardianship  
PO Box 2969  
Madison WI 53701-2969